



DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Part B/DMERC Provider

Report Date: 6/28/2004

Provider Number #: 9999999999999999 Sample Provider

RE: CMS 500-99-0009/0002 PSC CERT - REQUEST FOR MEDICAL RECORDS

Second Request

Dear Doctor/Medicare Provider:

This request for medical records/documentation is sent to you under a federally mandated program to monitor and improve the **accuracy of Medicare payments** to physicians and other providers. This is NOT a fraud investigation. This request for your records is the result of a random selection of billing records. Your cooperation in responding to this information request is essential to assuring and improving the accuracy of your Medicare payments. If you fail to provide the requested information, we will interpret your lack of response as services not rendered, and your local Medicare contractor will be directed to recover Medicare payment for these services.

Medicare - Comprehensive Error Rate Testing Program

The purpose of the CERT program is to determine the national, contractor specific, benefit category and provider type paid claim error rates. In accordance with Section 1833 of the Social Security Act, Medicare providers and/or suppliers must provide documentation and medical records to the CERT contractor upon request to support claims for Medicare services.

Compliant with HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) does not preclude you from sending requested medical records or documentation. Medicare beneficiaries, upon enrollment in the program, are informed of Medicare's use of their personal health information to carry out health care operations.

Medical Records/ Documentation Request

We are requesting medical records regarding the claim that is identified on the enclosed Medical Records/Documentation Attachment Pull List. A Medical Records/Documentation Attachment barcoded cover sheet is included with a control number that corresponds to the record on the Medical Records/Documentation Attachment Pull List. Please submit the **applicable documents** in the following list for the selected claim. Please adhere to the following directions when photocopying, packaging, and mailing the requested records. NOTE: Documents may be FAXED to (804) 864-9980 or (804) 264-3268.

- 1) Complete copies should include specific records to support the services on the claim identified on the Medical Records/Documentation Attachment Pull List, and would include as **applicable** the following documents:

- | | | |
|--|-----------------------------|------------------------------|
| - Physician Orders | - Physicians Progress Notes | - Emergency Room Records |
| - Diagnostic Test Results (regardless of where they are performed) | - Medication Records | - History and Physical Notes |
| | - Graphic Reports | - Operative Reports |
| | | - All Lab Reports |

Medicare CERT Operations

Medicare Part B/DMERC Provider

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Page 2

Report Date: 6/28/2004

1) Applicable Documents (continued).

- | | | |
|---------------------|------------------------------------|------------------------------------|
| - Nurses Notes | - Verbal Orders | - Home Health Progress Notes |
| - Hospice Records | - Skilled Nursing Facility Records | - Certificate of Medical Necessity |
| - Pathology Reports | - Ambulance Records (with mileage) | - Any additional information |
| - Progress Notes | | pertinent to this medical review |

2) Photocopy each record. Please make sure all copies are complete, legible, and contain both sides of each page, including page edges. Complete copies should include specific records to support the services on the claim identified on the Medical Records/Claim Attachment Pull List.

3) Complete and return the enclosed CERT Operations barcoded Medical Records/Claim Attachment Cover Sheet. A Medical Records/Claim Attachment Cover Sheet should be attached to each set of documentation. If documentation for more than one claim is included in the response, please attach each Medical Records/Claim Attachment Cover Sheet to the appropriate documentation.

4) Mail the records to the following CERT Operations address. NOTE: You may FAX records to (804) 864-9980 or (804) 264-3268.

CERT Operations Center
Attn: Disposition Department - Distribution
1530 E. Parham Road
Richmond, VA 23228

We are not authorized to reimburse providers/suppliers for the cost of claims/medical records duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT Operations Center.

The requested documentation is due **within 60 days of receipt of this letter**. If the requested information is not received within this time period, CERT Operations will assume that the services on the claim were not rendered. Your local Medicare contractor will pursue overpayment recoupment for these undocumented services.

Thank you for your cooperation and prompt attention in this matter. If you have questions or comments, please contact the CERT Operations Center at 804-264-1778, ext 164.

Sincerely yours,

John L. Simpson
Program Director
CERT Operations Center

Enclosures

Medicare CERT Operations
CMS 500-99-0009/0002 PSC CERT
Medical Records/Claim Attachment Pull List

Medicare Part B/DMERC Provider

Provider #: 999999999999999 Sample Provider

Report Date: 6/28/2004

Patient Name:	First M Lastname	Date of Birth:	1/1/1900
Service From/To Dates:	1/1/2004 - 1/1/2004	CERT Claim ID (CID):	999996
HICNUM:	999999999999	Claim Date:	6/30/2004
Claim Control Number (CCN):	999999999999999999999999		

<u>Performing</u> <u>Provider</u>	<u>Provider</u> <u>Specialty</u>	<u>Diagnosis</u> <u>Code</u>	<u>Hcpcs</u> <u>Code</u>	<u>Hcpcs</u> <u>Modifier 1</u>	<u>Hcpcs</u> <u>Modifier 2</u>	<u>Hcpcs</u> <u>Modifier 3</u>	<u>Hcpcs</u> <u>Modifier 4</u>
999999999999999	A5	20800	K0001	RR	KJ	BU	

**Medicare CERT Operations
CMS 500-99-0009/0002 PSC CERT
Medical Records/Claim Attachment Cover Sheet**

Medicare Part B/DMERC Provider

Provider #: 9999999999999999 Sample Provider

Report Date: 6/28/2004

Please fill in the requested information below:

Request filled by:

Contact Phone Number:



Fax Number:

Date:

Please copy both sides of each page and please DO NOT cut off page edges when copying. Please attach the original copy of this barcoded cover sheet to a copy of the medical record noted below. The record must be clipped or rubber-banded with the original cover sheet in order to ensure proper validation of receipt by the CERT Operations Center. No staples please.

**Please fax documentation to: (804) 864-9980 or (804) 264-3268
or send documentation to:**

**CERT Operations Center
Attn: Disposition Dept - Distribution
1530 E. Parham Road
Richmond, VA 23228**

Beneficiary Name:	First M Lastname
Date of Birth:	1/1/1900
Claim Control Number:	99999999999999999999999999999999
HICNUM:	999999999999
Service From/To:	1/1/2004 - 1/1/2004
Provider Number:	99999999999999999999999999999999 Sample Provider
Sampreas:	999999O00
Contractor Type:	Part B/DMERC
AC #:	99999 Sample Contractor
Universe Date:	JUN 2004
 <i>Scan Area</i>  	
CID: 999996 	
Mail Sequence: Second Request 